Dr. Kramer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10134

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parsonsburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS P.B. Hoyt.	STREET ADDRESS (If rural, give location) R.D.#1.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Fannie	M.	Adkins	Oct.	19	49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	White	Single	July 18- 1868	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	R.D.#1. Parsonsburg	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William S. Adkins	Betsey McGee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No.		Mrs. Clarence A. Adkins R.D.#1. Parsonsburg Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-sclerosis & Hypertension	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

331
83a

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 10/4, 19 49, to 10/19, 19 49, that I last saw the deceased alive on 10/19, 19 49, and that death occurred at 10.06 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Lloyd R. Kramer	M.D.	Salisbury, Md.	10/21/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct. 22-49	Locust Grove Cem.	near Parsonsburg	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-22-49	Mary W. Holloway Deputy	Holloway & G. Salisbury Walter R. Holloway	Md.

RECEIVED
OCT 23 1919
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10135

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eden Rural 2; LENGTH OF STAY (in this place) 50 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eden Rural 2; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Burn (Middle) (Last) Barkley

4. DATE OF DEATH: (Month) Oct. (Day) 26 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: March 4, 1872

9. AGE last birthday: 77 yrs. If under 1 year: Months 7 Days 28 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Eden, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Art Barkley Md.

14. MOTHER'S MAIDEN NAME: Esther Graham Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY No.: no

17. INFORMANT: Mrs Burm Barkley Eden, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.1 Immediate cause (a) Congestive Heart Failure — Interval Between Onset and Death: 2-3 yrs.

932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ~~June~~ 10-1-49 A.M., 19..., to 10-26, 19..., that I last saw the deceased alive on 10-26, 19 49, and that death occurred at 6 40 A. m., from the causes and on the date stated above.

SIGNATURE Lee L. Lowry (Degree or title) M.D. ADDRESS Fruitland Md. DATE SIGNED 10-29-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Io-30-49 | NAME OF CEMETERY OR CREMATORY Allen Cemetery | LOCATION (City, town, or county) (State) Allen, Maryland

DATE REC'D BY LOCAL REG. 10-29-49 | REGISTRAR'S SIGNATURE Mary M. Holloway Deputy | 24. FUNERAL DIRECTOR ADDRESS Levin R. Wilson Princess Anne, Md.

RECEIVED
NOV 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10136

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Worcester; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; LENGTH OF STAY (In this place) 3 hours.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Stockton; STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print): (First) John; (Middle) E; (Last) Bevans

4. DATE OF DEATH: (Month) Oct; (Day) 18; (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) --

8. DATE OF BIRTH: March 17 1862

9. AGE last birthday: 87 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Mercantile

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank E. Bevans

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Mrs Everette Duncan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

819.5 **Immediate cause** (a) Crushing chest wounds with internal injuries — Abt Hours

1700 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to a fall from an automobile while skidding on highway

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (Ran into an embankment)

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway (CITY OR TOWN) Pocomoke (COUNTY) Worcester (STATE) Md

TIME OF INJURY (Month) Oct (Day) 18 (Year) 49 (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☒ HOW DID INJURY OCCUR? Car which was struck by car which ran off road

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Dr W E Santorum (Degree or title) M.D. ADDRESS Pocomoke City Md DATE SIGNED 10/21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Oct 21, 1949 | NAME OF CEMETERY OR CREMATORY Bethany M.P. Cemetery | LOCATION (City, town, or county) Pocomoke, Worcester (State) Md.

DATE REC'D BY LOCAL REG. 10-20-49 | REGISTRAR'S SIGNATURE Mary W. Holloway Deputy

24. FUNERAL DIRECTOR Henry H. Watson ADDRESS Pocomoke Md

VS. A15A

RECEIVED
OCT 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10137

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 10 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Girdletree
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Della		Blake	October	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
Female	Colored	Married	Dec 23-1917	32/10 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Girdletree, Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Holland	Cordelia Hudson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Vanoy Blake Girdletree Md (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

642.5 **Immediate cause** (a) Cardiac Failure

Antecedent cause(s)

146b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Toxemia of Pregnancy.

(c) Premature alparation of Placenta

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Oct 15, 49	Premature Separation of Placenta	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 16, 19 49, to Oct 23, 19 49, that I last saw the deceased alive on 10-22, 19 49 and that death occurred at 4 15 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm B. Smith	M.D.	Salisbury, Md.	10/23/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 26/49	Woodlawn	Girdletree	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-24-49	Mary W. Holloway Deputy	Elay E. Timmins	Snow Hill Md

RECEIVED
OCT 28 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10138

CERTIFICATE OF DEATH

Reg. Dist. No. 332

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C

I

VS. A15

1. PLACE OF DEATH
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland, COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eden.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Girl (Last) Bromley.

4. DATE OF DEATH: (Month) Oct. (Day) 15 (Year) 1949

5. SEX: Female.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Oct. 15-1949

9. AGE last birthday yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min. 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): md. Peninsula General Hospital

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Bromley, Norman Ellis

14. MOTHER'S MAIDEN NAME: Thomas, Thelma Elizabeth.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Unknown - Membranes ruptured at 6 mos. pregnancy.

761.5 Antecedent cause(s)

160 C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15 49, to Oct 15 49, that I last saw the deceased alive on Oct 15, 49, and that death occurred at 8:19 P m., from the causes and on the date stated above.

SIGNATURE: Wm R Mann (Degree or title) Rep ADDRESS: Salisbury Md DATE SIGNED: 10/16/49

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation DATE: 10-16-49. NAME OF CEMETERY OR CREMATORY: Peninsula General Hospital LOCATION (City, town, or county) (State): Salisbury, Md.

DATE REC'D BY LOCAL REG.: 10-17-49 REGISTRAR'S SIGNATURE: Mary W. Holloway, Deputy

24. FUNERAL DIRECTOR: Peninsula General Hospital - Salisbury, Md. ADDRESS

RECEIVED
OCT 19 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10139

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY WICOMICO; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY, MD. RURAL; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY WICOMICO; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN QUANTICO; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
VIRGINIA	MAE	BUTLER	OCTOBER	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	A A	MARRIED	1-6-1915	34 yrs.	8	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FACTORY	DULANY'S	MARYLAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
HERMAN WALKER	ALBERTA MITCHELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO	213-22-4759	MRS. ALICE JOHNSON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) CRUSHING INJURY OF SKULL	SUDDEN
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) AUTOMOBILE ACCIDENT	
	(c)	

819.5
170C

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	HIGHWAY	NEAR SALISBURY	WICOMICO	MARYLAND

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☒	HOW DID INJURY OCCUR?
10	23	1949	10 A. m.			AUTOMOBILE ACCIDENT - Ran into pole

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward F. Fowler	M.D.	Salisbury, Md	10/25/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	10-26-49	MT. ZION CEMETERY	QUANTICO	MARYLAND

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-27-49	Mary W. Holloway Deputy	James F. Stewart	402 E. Church St Salisbury, Md.

VS. A15A

RECEIVED
OCT 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10140

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): 208 Monument Square

3. NAME OF DECEASED (Type or Print): (First) Willis (Middle) Cleveland (Last) Carey

4. DATE OF DEATH: (Month) October (Day) 15 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 29-1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Millwright

10b. KIND OF BUSINESS OR INDUSTRY: Furniture store

11. BIRTHPLACE (State or foreign country): Wicomico Co. Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ebenezer Carey

14. MOTHER'S MAIDEN NAME: Mary Sally Nimtow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Sarah L. Carey (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	3 days
Antecedent cause(s)	(b) Cerebral Arteriosclerosis	Symptom 5 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Essential Hypertension	2 yrs

331
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Hypertensive heart disease — 1 yr.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Oct 12, 1949, to Oct. 15, 1949, that I last saw the deceased alive on 10/15, 1949, and that death occurred at 2:50 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title): David J. Gilmore M.D. — ADDRESS: Salisbury Md. — DATE SIGNED: Oct. 15, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 17-49 — NAME OF CEMETERY OR CREMATORY: Parsons Cem. — LOCATION (City, town, or county) (State): Salisbury Md

DATE REC'D BY LOCAL REG.: 10-17-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy

24. FUNERAL DIRECTOR — ADDRESS: Holloway & Co. Salisbury Md. — Walter K. Holloway

RECEIVED
OCT 19 1949
BUREAU V. A.

10141

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH — COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Stockton
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Baby (2) (Middle) Thomas Albert (1) (Last) Collick
4. DATE OF DEATH: (Month) October (Day) 9 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: August 12, 1949
9. AGE last birthday: yrs. — If under 1 year: Months 2, Days 27 — If under 24 hrs: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Maurice Collick
14. MOTHER'S MAIDEN NAME: Cleola Lucas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Maurice Collick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

770.0 Immediate cause (a) Renal Acidosis and Uremia — 48 hrs

Antecedent cause(s)

161 C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Erythroblastosis Foetalis — life

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 9:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Raymond G. Berggren M.D. Peninsula Gen. Hosp. Salisbury 10/10/49

23. BURIAL, CREMATION REMOVAL (Specify): Bur. — DATE: 10-10-49 — NAME OF CEMETERY OR CREMATORY: Johnson's Neck Cemetery — LOCATION (City, town, or county) (State): Pocomoke City, R. 2 Maryland
DATE REC'D BY LOCAL REG.: 10-10-49 — REGISTRAR'S SIGNATURE: Maryll Holloway Deputy — 24. FUNERAL DIRECTOR: Irvine Bennett — ADDRESS: Stockton Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 17 1949
BUREAU V. S.

Dr. Gow

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10142

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
HOSPITAL OR INSTITUTION OR STREET ADDRESS 415. Dock st.	STREET ADDRESS (If rural, give location) 415. Dock st.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Washington	Collins	Oct.	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	single	July 4-1860	89 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Farmer	Salisbury Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William H. Collins	Catherine Holloway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No.			Mrs. Esa Boyce - Wilmington Del

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac Failure	3 hrs
422.1 Antecedent cause(s)	(b) Paroxysmal Cardiac Dyspnoea	2 yrs
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerotic C-V- Disease.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 7/3/49, 19....., to 10/20/49, 19....., that I last saw the deceased alive on Oct. 20., 1949., and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Robert Gow MD	Salisbury Maryland	10/22/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 24-49	Parsons Cem.	Salisbury Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-22-49	Mary W. Holloway Deputy	Holloway & Holloway Walter K. Holloway	Salisbury Md.

RECEIVED
OCT 25 1949
BUREAU V. S.

10143

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

M

1. PLACE OF DEATH: COUNTY Wicomico Co. Md. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Sadie (Middle) Edith (Last) Collins

4. DATE OF DEATH (Month) 10 (Day) 28 (Year) 1949

5. SEX Female
6. COLOR OR RACE A A
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 9-3-1893
9. AGE last birthday 56 yrs. If under 1 year Months 1 Days 25 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Frank H. Jones
14. MOTHER'S MAIDEN NAME Angeline Stanford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. No
17. INFORMANT Mrs. Ruth V. Collins Harris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

170 Immediate cause (a) Congestive Heart Failure

50 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer of Right Breast.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Sept 18, 1948
19b. MAJOR FINDINGS OF OPERATION Large Penetrating Mass of Rt Breast. Secondaries in Body.
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1st 1949, to Oct 26, 1949, that I last saw the deceased alive on Oct 26, 1949, and that death occurred at 3:50 m., from the causes and on the date stated above.

SIGNATURE C. J. Hearn M. (Degree or title) ADDRESS 203 W Church St Salisbury DATE SIGNED 10/28/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-31-49
NAME OF CEMETERY OR CREMATORY Mt. Calvary
LOCATION (City, town, or county) Fruitland (State) Md.

DATE REC'D BY LOCAL REG. 10-29-49
REGISTRAR'S SIGNATURE Mary W. Holloway Deputy
24. FUNERAL DIRECTOR James F. Stewart ADDRESS 402 E. Church St. Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
NOV 1 1949
BUREAU U. S.

Dr. Neame

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10144

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) F. (Last) Colona

4. DATE OF DEATH (Month) Oct. (Day) 14 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH 1874

9. AGE last birthday 75 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Stockton, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert W. Colona

14. MOTHER'S MAIDEN NAME Annie B. Fayton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Mr. Shaver C. Tull Pocomoke City, Md Rural #2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) ~~Charles Colona~~ Cardiac Embolism 17 Days

Antecedent cause(s) Cardiac Embolism

940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial Failure

(c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis Associated c̄ Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 8, 1949, to October 14, 1949, that I last saw the deceased alive on Oct 14, 1949, and that death occurred at 5:09 p.m., from the causes and on the date stated above.

SIGNATURE Carrie I. Hearn (Degree or title) MD ADDRESS 203 W Church St. Salisbury DATE SIGNED 10/18/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Oct. 16/49 NAME OF CEMETERY OR CREMATORY Methodist LOCATION (City, town, or county) Stockton Wicomico (State) Md

DATE REC'D BY LOCAL REG. 10-19-49 REGISTRAR'S SIGNATURE Mary W. Holloway Deputy

24. FUNERAL DIRECTOR Clay E. Ammin ADDRESS Snow Hill, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
OCT 21 1949
BUREAU

10145

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Quantico
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Quantico
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) LAURA (Middle) FRANCES (Last) CONWAY

4. DATE OF DEATH (Month) Oct. (Day) 25 (Year) 1949

5. SEX Female
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Mar. 15, 1870
9. AGE last birthday 79 yrs. If under 1 year: Months 7, Days 25; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Quantico, Md.
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME John Dashield
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Georgia Conway - Quantico, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure — 2 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio Vascular disease — ?

(c) Generalized Arteriosclerosis — ?

422.1

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 3/16, 1946 to Oct 25, 1949, that I last saw the deceased alive on Oct 25, 1949, and that death occurred at 10:00 P.m., from the causes and on the date stated above.

SIGNATURE Robert J Goodman (Degree or title) ADDRESS 302 N. Division St., Salisbury, Md DATE SIGNED 10/28/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE Oct. 28, 1949
NAME OF CEMETERY OR CREMATORY Head of Creek Cem.
LOCATION (City, town, or county) (State) Quantico, Maryland.

DATE REC'D BY LOCAL REG. 10-28-49
REGISTRAR'S SIGNATURE Mary W. Holloway Deputy
24. FUNERAL DIRECTOR C. G. Messick, ADDRESS Bivalve, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS1A15

RECEIVED
FEB 29 1949
BUREAU V. S.

Evidence for addition in #18b shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10146

CERTIFICATE OF DEATH

Reg. Dist. No. 332

FILM No. G 122 NOV 23 1949

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury | LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Genl Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hebron
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Walter	M.	Cordrey	Oct.	14	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
male	White	Married	Aug 28 1893	56 yrs.	1	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	farms	Hebron Md	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin H. Cordrey	Mary Galloway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	xx	Mrs Walter M. Cordrey Hebron md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	Instant
490 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 108	(b) Pneumonia - Lobar (11/22/49 0.S)	6 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
✓		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 9, 1949, to Oct 14, 1949, that I last saw the deceased alive on 10/14, 1949, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
W. M. Huck	Salisbury Md	10-14-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-17-49	Wicomico Memorial Pk	Salisbury Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-17-49	Mary W. Holloway	Lewis B. Wilson	Princess Anne, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 19 1949
BUREAU T. S.

10147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md. COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 114. Pinehurst Ave.	STREET ADDRESS (If rural, give location): 114. Pinehurst Ave

3. NAME OF DECEASED (Type or Print): (First) Virginia (Middle) Hester (Last) Darkiell

4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 49

5. SEX: female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: April 6-1901

9. AGE last birthday: 48 yrs. — If under 1 year: Months 9 Days 16 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): R.D. Mardela Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Harlen Twilley

14. MOTHER'S MAIDEN NAME: Minnie Bacon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mr. Edward B. Darkiell (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinomatosis (generalized) — 2 years.

170 Antecedent cause(s)

50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Breast — 2 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 19, 1947, to Oct. 22d, 1949, that I last saw the deceased alive on Oct 22, 1949, and that death occurred at 1205a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Class F. Fisher, M.D. Salisbury, Md 10/24, '49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct. 24-49 — NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park — LOCATION (City, town, or county) (State): Salisbury Md

DATE REC'D BY LOCAL REG.: 10-24-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy — 24. FUNERAL DIRECTOR: Holloway & Co. Salisbury Md. — ADDRESS: Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 26 1949
BUREAU V. S.

10148

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH · COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE New Jersey COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 7 month	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbury
HOSPITAL OR INSTITUTION OR STREET ADDRESS Woodlyn	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Riley (Middle) Davis (Last)			4. DATE OF DEATH (Month) 10 (Day) 28 (Year) 1949	
5. SEX Male	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Not Known	9. AGE last birthday Not Known — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Non	10b. KIND OF BUSINESS OR INDUSTRY Non	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? Accomac	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT Perless Holden		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause	(a) Coronary Thrombosis	12 days
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Heart Disease	Indefinite
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 2, 1949, to Oct 28, 1949, that I last saw the deceased alive on Oct 28, 1949, and that death occurred at 5 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E. A. Purnell	M.D.	800 W Main ST Salisbury, Md	Oct. 29, 1949

23. BURIAL, CREMATION ~~REMOVAL~~ (Specify)	DATE THEREOF Nov 1 1949	NAME OF CEMETERY OR CREMATORY [illegible]	LOCATION (City, town, or county) (State) Woodbury, New Jersey
DATE REC'D BY LOCAL REG. 10-29-49	REGISTRAR'S SIGNATURE Mary W. Holloway Deputy Odd Fellows Cemetery	24. FUNERAL DIRECTOR William H. Jones	ADDRESS Francis J. Amer Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 1 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10149

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Rolus (Middle) Edward (Last) Dennis Jr.

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 5-24-44

9. AGE last birthday: 1 yrs. — If under 1 year: Months 4 Days 12 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Newark, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rolus Edward Dennis, Sr.

14. MOTHER'S MAIDEN NAME: Beatrice Manuel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Rolus E. Dennis, Sr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
343	Immediate cause	(a) ~~Spontaneous~~ WCM subarachnoid hemorrhage	16 hours
83a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Encephalitis, nonspecific	24hrs P
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 5, 1949, to Oct. 6, 1949, that I last saw the deceased alive on Oct 6, 1949 and that death occurred at 3:32P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William C. Morgan M.D. 502 N Division St. Salisbury Md. 10/6/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 10-8-49 — NAME OF CEMETERY OR CREMATORY: Cedar Chapel — LOCATION (City, town, or county): Newark — (State): Md.

DATE REC'D BY LOCAL REG. 10-7-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway, Deputy

24. FUNERAL DIRECTOR: James F. Stewart — ADDRESS: 402 E. Church St. Salisbury, Md.

RECEIVED
OCT 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10150

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury Md.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill R.R. #2
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Baby Girl (Middle) (Last) Dix

4. DATE OF DEATH (Month) 10 (Day) 31 (Year) 1949

5. SEX Female

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH 10/30/49

9. AGE last birthday yrs. If under 1 year Months. 1 Days 1 If under 24 hrs Hours 10 Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Salisbury Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Unwed

14. MOTHER'S MAIDEN NAME Mable Dix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Mable Dix, Snow Hill, Md. R.R.2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776 Immediate cause (a) Prematurity

Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) None determined

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-30, 1949, to 10-31, 1949, that I last saw the deceased alive on 10-31, 1949 and that death occurred at 2:20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

N. G. B. Smith M.D. Salisbury, Md. 10-31-49

23. BURIAL, CREMATION REMOVAL (Specify) ✓ DATE 11/1/49 NAME OF CEMETERY OR CREMATORY Peninsula General Hospital LOCATION (City, town, or county) Salisbury Maryland (State)

DATE REC'D BY LOCAL REG. 11-1-49 REGISTRAR'S SIGNATURE Mary W. Holloway Deputy

24. FUNERAL DIRECTOR Peninsula General Hospital ADDRESS Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10151

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury Md. — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark R 2 D
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ella	Cecelia	Foreman	Oct.	31	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs: Hours / Min.
Female	W		Apr. 1949	yrs.	6	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Newark Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Foreman	Edna Pennell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Diarrhea, Et. undetermined	3 days
571.0 Antecedent cause(s)		
119.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Raymond S. Berggren MD	Peninsula Gen. Hosp. Salisbury Md.	1 Nov. '49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 3 1949	Cedar Chapel	Newark Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-4-49	Mary W. Holloway Deputy	Anna A. Bunting	Berlin Md.

RECEIVED
NOV 7 1949
BUREAU V. S.

Evidence for change of birth date is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10152

CERTIFICATE OF DEATH

FILM No. G 122 OCT 21 1949

Reg. Dist. No. 232

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; LENGTH OF STAY (In this place) Since 8/10/49; HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Kendall	William	Gaskins		October	10	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Divorced	8/17/1877	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter		Ocean City, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edgar Gaskins	Ada Hastings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	222-01-6812	Patient on admission to hospital

002

13b

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	3 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 8/10, 1949, to 10/10, 1949, that I last saw the deceased alive on Oct. 10, 1949, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
S. B. Hunter	MD	Salisbury, Md.	10/10/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	10/13/49	Evergreen	Berlin	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-13-49	Mary W. Holloway Deputy	Thos. A. Bishop	Berlin MD

RECEIVED
OCT. 18, 1949
BUREAU V. S.

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10153

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 120 Lincoln Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): 120 Lincoln Ave

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Jefferson (Last) Godfrey

4. DATE OF DEATH: (Month) Oct. (Day) 26 (Year) 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: Sept. 28. 1862

9. AGE last birthday: 87 yrs. If under 1 year: Months 0, Days 29. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Worcester Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Godfrey

14. MOTHER'S MAIDEN NAME: Susan Godfrey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Welton Godfrey 118 Lincoln Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 **Immediate cause** (a) Cerebral Hemorrhage — Interval Between Onset and Death: 3 days

924 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension, Valvular Heart disease — 10 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Hypostatic Pneumonia — Unknown

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 2, 1949, to Oct 26, 1949, that I last saw the deceased alive on Oct 25, 1949, and that death occurred at 8:45 P. m., from the causes and on the date stated above.

SIGNATURE: Lewis R Mann (Degree or title): MD ADDRESS: Salisbury Md DATE SIGNED: 10/27/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 28/49 — NAME OF CEMETERY OR CREMATORY: Parsons Cemetery — LOCATION (City, town, or county) (State): Salisbury Md

DATE REC'D BY LOCAL REG.: 10-28-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy

24. FUNERAL DIRECTOR: Holloway & Co. — ADDRESS: 520 Church St. Salisbury Md.

VS. A13

RECEIVED
OCT 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10154

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY Accomack; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Church; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Stuart (Last) Goff

4. DATE OF DEATH: (Month) October (Day) 15 (Year) 1949

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Sept. 22, 1949

9. AGE last birthday: yrs. If under 1 year: Months; Days 23; If under 24 hrs: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): New Church, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jas. S. Goff

14. MOTHER'S MAIDEN NAME: Mary Louise Shulde

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Jas. Goff, New Church, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

756.2 Immediate cause (a) Congenital Atresia of Small and large Intestine — 1 Hr

Antecedent cause(s)

157 M Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Above

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 10/15, 19 49, and that death occurred at 6:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Raymond B. Berggren MD P.O. Hosp. Salisbury Md. 10/15/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE: Oct. 16, 1949; NAME OF CEMETERY OR CREMATORY: Downing; LOCATION (City, town, or county) (State): Oak Hall, Va

DATE REC'D BY LOCAL REG. 10-18-49

REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy

24. FUNERAL DIRECTOR ADDRESS: D. A. Shulds, New Church, Va

RECEIVED
OCT 20 1949
BUREAU Y. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10155

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 13 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Genl Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela Springs
STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print): (First) Wilson (Middle) Archie (Last) Goslee

4. DATE OF DEATH: (Month) 10 (Day) 28 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: a a

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 12-9-1902

9. AGE last birthday: 46 yrs. — If under 1 year: Months 10, Days 19 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edward Goslee

14. MOTHER'S MAIDEN NAME: Annie G. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-4711

17. INFORMANT: Royce L. Goslee

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Myocardial Insufficiency — Interval between onset and death: Symptoms 6 mos.

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Heart Disease — —

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 28, 1949 to Oct. 28, 1949, that I last saw the deceased alive on Oct. 28, 1949, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) David J. Gilmore M.D. — ADDRESS Salisbury Md. — DATE SIGNED Oct. 30, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 11-1-49 — NAME OF CEMETERY OR CREMATORY: Zion Cemetery — LOCATION (City, town, or county) (State): Sharptown, Wicomico Md.

DATE REC'D BY LOCAL REG. 10-31-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy — 24. FUNERAL DIRECTOR: James F. Stewart — ADDRESS: 402 E Church St. Salisbury, Md.

RECEIVED
NOV 4 1949
BUREAU V. S.

Dr. Gore.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10156

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH — COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 609 W. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): 609 W. Main St.

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) May (Last) Griffin
4. DATE OF DEATH: (Month) Oct. (Day) 27 (Year) 49
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: July 19, 1890
9. AGE last birthday: 59 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop. - Restaurant
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Berlin Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Gillis Holloway
14. MOTHER'S MAIDEN NAME: Widgeon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs. Theresa Cordrey (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

155 Immediate cause (a) Respiratory Failure — 36 hrs.

Antecedent cause(s)

46f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastatic Ca, Cerebral — ?

(c) Carcinoma of Gall Bladder — 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8/21/47
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Gallbladder
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 28, 1949, to Oct. 27, 1949, that I last saw the deceased alive on Oct. 27, 1949, and that death occurred at 2:55 P. m., from the causes and on the date stated above.

SIGNATURE: Robert J Gore. (Degree or title) — ADDRESS: Salisbury Md. — DATE SIGNED: 10-27-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct 30/49 — NAME OF CEMETERY OR CREMATORY: Wic. Min. Park. — LOCATION (City, town, or county): Salisbury (State): Md.

DATE REC'D BY LOCAL REG.: 10-28-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy — 24. FUNERAL DIRECTOR: Holloway & Co. — ADDRESS: 520 Church St. Salisbury Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 29 1949
BUREAU V. S.

RECEIVED
29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10157

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury | LENGTH OF STAY (in this place): 2 yrs. 4 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Wright's Nursing Home, Davis St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Talbot
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: St. Michaels
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) J. (Middle) HARRY (Last) HAUSE

4. DATE OF DEATH: (Month) Oct (Day) 5 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Nov 20, 1870

9. AGE last birthday: 78 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St. Michaels, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Hause

14. MOTHER'S MAIDEN NAME: Elizabeth A. Higgins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Charles M. Dyott, St. Michaels, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 **Immediate cause** (a) Congestive Heart Failure — 2 mo.

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic C-V-D — ?

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 7, 1949, to Oct 5, 1949 that I last saw the deceased alive on Aug 7, 1949, and that death occurred at 11:00 P m., from the causes and on the date stated above.

SIGNATURE Robert Graves (Degree or title) ADDRESS DATE SIGNED 10-5-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct 8, 1949 | NAME OF CEMETERY OR CREMATORY: Olivet Cemetery | LOCATION (City, town, or county) (State): St. Michaels, Md.

DATE REC'D BY LOCAL REG. 10-7-49 | REGISTRAR'S SIGNATURE: Maryll W. Holloway Deputy

24. FUNERAL DIRECTOR ADDRESS: Newnam & Harrison, St. Michaels, Md.

VS. A15

RECEIVED
OCT 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10158

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne.
STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED (Type or Print): (First) Cyprose (Middle) Baby Boy (Last) Hayward
4. DATE OF DEATH: (Month) October (Day) 20 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
Male	Colored.		Aug 14, 1949	yrs.	2	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Salisbury Md	

13. FATHER'S NAME Thomas H. Hayward
14. MOTHER'S MAIDEN NAME Caroline Boston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Thomas H. Hayward

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

774 **Immediate cause** (a) Potassium Intoxication — 12 hrs.

Antecedent cause(s)

107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Aspiration Pneumonia — 3 days

(c) Prematurity — life

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 12:15 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Raymond S. Bergren MD	Peninsula Gen. Hosp. Salisbury	20 Oct. '49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	10-20-49	Hebron	Princess Anne Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-20-49	Mary W. Holloway Deputy	William H. James Jr.	Princess Anne Md.

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 20 1949
BUREAU V. S.

Dr. Lewis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10159

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hallard — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hallard
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Roger (Middle) C. (Last) Hearn
4. DATE OF DEATH: (Month) Oct. (Day) 19 (Year) 49
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: March 27-
9. AGE last birthday: 894 55 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Poultry Man)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hallands Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles R. Hearn
14. MOTHER'S MAIDEN NAME: Mary Lynn Dennis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): World War #1.
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Mrs. Maggie E. Hearn Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
447	Immediate cause	(a) Chronic interstitial nephritis	10 yrs
	Antecedent cause(s)		
131a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension arteriosclerosis	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN) (COUNTY) (STATE): —
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, 19..., to 10-19-, 1949, that I last saw the deceased alive on 10-19-, 1949, and that death occurred at 8:15 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank R Lewis	M.D.	Hallands Maryland	10-22-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct. 22-49	Hallands Cem.	Hallands	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-22-49	Mary W. Holloway Deputy	Holloway & Co. Salisbury Md. Walter R. Holloway	

RECEIVED
OCT 25 1949
BUREAU V. S.

Dr. Gibson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10160

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; MARYLAND; LENGTH OF STAY (in this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Somerset; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne; STREET ADDRESS (If rural, give location) Route #2.

3. NAME OF DECEASED (Type or Print): (First) Mrs Ella; (Middle) Nora; (Last) Hopkins

4. DATE OF DEATH: (Month) Oct. (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Oct. 30 1870

9. AGE last birthday: 78 yrs. If under 1 year: Months 11, Days 13; If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Mt. Vernon Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George B. Marsh

14. MOTHER'S MAIDEN NAME: Ella Nora Sims

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mr. Raymond W. Hopkins Salisbury Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Acute Coronary Artery Occlusion — Interval Between Onset and Death: 10 days

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Artery Arteriosclerosis — Symptoms 5 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 3, 1949 to Oct. 13, 1949, that I last saw the deceased alive on Oct. 13, 1949, and that death occurred at 2:55 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

David J. Gibson M.D. Salisbury Md. 10/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 10-16-49 | NAME OF CEMETERY OR CREMATORY: Asbury M. E. Cemetery | LOCATION (City, town, or county) (State): Mt. Vernon Md

DATE REC'D BY LOCAL REG.: 10-14-49 | REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy

24. FUNERAL DIRECTOR ADDRESS: Leon R. Wilson Princess Anne, Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10161

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 5 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela
STREET ADDRESS (If rural, give location) Main street

3. NAME OF DECEASED (Type or Print): (First) Wayne (Middle) DAVID. (Last) HORSMAN Horseman

4. DATE OF DEATH: (Month) 10 (Day) 8 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Jan. 29-1943

9. AGE last birthday: 6 yrs. If under 1 year: Months 8 Days 7 — If under 24 hrs: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): New Haven Conn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wayne J. Horsman

14. MOTHER'S MAIDEN NAME: Margaret Tobin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mr. Wayne J. Horsman (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Depressed Fractured Skull — Interval Between Onset and Death: 5 hours

813.5 Antecedent cause(s)

170 C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Brain Injury — 5 hours

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-8-49

19b. MAJOR FINDINGS OF OPERATION: Fractured Skull - Depressed, Brain Injury

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

PLACE (Home, farm, factory, street, office bldg., etc.): Highway — (CITY OR TOWN) Mardella — (COUNTY) Wicomico — (STATE) Md

TIME OF INJURY (Month) 10 (Day) 8 (Year) 49 (Hour) 5 p.m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? struck by car while riding Bicycle

22. I hereby certify that I attended the deceased from ..... 19..... to ..... 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 10 50 p.m., from the causes and on the date stated above.

medical examiner autopsy

SIGNATURE (Degree or title): Paul Schroeder M.D. Deputy Med Exam — ADDRESS: Salisbury Md — DATE SIGNED: 10-8-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 11-49 — NAME OF CEMETERY OR CREMATORY: Mardela Cem. — LOCATION (City, town, or county) (State): Mardela Maryland

DATE REC'D BY LOCAL REG. 10-10-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy

24. FUNERAL DIRECTOR: Holloway & C. Salisbury Md — ADDRESS: Walter R. Holloway

VS. A15

RECEIVED
OCT 12 1949
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10162

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 520 Franklin St

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) William Samuel Humphreys

4. DATE OF DEATH (Month) (Day) (Year) Oct 12 - 49

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 25 - 1896
9. AGE last birthday 52 yrs. If under 1 year: Months 10 Days 17 If under 24 hrs: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Mgr.
10b. KIND OF BUSINESS OR INDUSTRY Bakery Co.
11. BIRTHPLACE (State or foreign country) Salisbury Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Fountain Humphreys
14. MOTHER'S MAIDEN NAME Margaret Ann Cordrey (Write)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) Yes Wed Nov. 1 -
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mr. Biddy Lee Humphreys

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary Disease	1 3/4 hrs
	Antecedent cause(s)		
94a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Unknown.	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 12:05 m., from the causes and on the date stated above.

SIGNATURE Clearly Fisher Jr. (Degree or title) ADDRESS Salisbury, Md. DATE SIGNED 10-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Oct. 19-49
NAME OF CEMETERY OR CREMATORY Shad Point Cem.
LOCATION (City, town, or county) Shad Point (State) Md

DATE REC'D BY LOCAL REG. 10-17-49
REGISTRAR'S SIGNATURE Mary W. Holloway Deputy
24. FUNERAL DIRECTOR Holloway & Co. Salisbury Md. Walter R. Holloway
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 19 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10163

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: COUNTY Wicomico; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS P.H. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parsonsburg; STREET ADDRESS (If rural, give location) R.D.

3. NAME OF DECEASED (Type or Print): (First) Antonio (Middle) (Last) Jordano

4. DATE OF DEATH: (Month) Oct. (Day) 11 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: June 13 1887

9. AGE last birthday: 62 yrs. If under 1 year: Months 3 Days 23 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Naples Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Jordano

14. MOTHER'S MAIDEN NAME: Mrs. Pedone (Stella)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Joseph Giordano (son) R.D. #3 Delmar Road Salisbury Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes, anemia, Arteriosclerosis (c) C-V Disease

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

260

61

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Spring, 19 49, to Oct 11, 19 49, that I last saw the deceased alive on Oct 10, 19 49, and that death occurred at 5:20 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William D Gray, MD Salisbury, Md 10/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Oct. 13-49

NAME OF CEMETERY OR CREMATORY: Pharone Cem.

LOCATION (City, town, or county) (State): Salisbury Md.

DATE REC'D BY LOCAL REG. 10-13-49

REGISTRAR'S SIGNATURE: Harold D. Holloway Deputy

24. FUNERAL DIRECTOR: Holloway & Holloway

ADDRESS: Salisbury Md

Walter D Holloway

VS-A 15

RECEIVED
OCT 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10165

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Wicomico; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury.; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MaryLand; COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FruitLand; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Girl (Last) Jones

4. DATE OF DEATH: (Month) October (Day) 8 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: October 7, 1949

9. AGE last birthday: one day yrs. If under 1 year: Months. Days. If under 24 hrs: Hours 23 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MaryLand -

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unnamed

14. MOTHER'S MAIDEN NAME: Jones, Josephine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Sues.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/7, 1949, to 10/8, 1949, that I last saw the deceased alive on 10/8, 1949, and that death occurred at 7 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. B. Smith M. D. Salisbury Md. 10/9-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

10-9-49 | Peninsula General Hospital | Salisbury, Md

DATE REC'D BY LOCAL REG. 10-10-49 | REGISTRAR'S SIGNATURE Mary W. Holloway Deputy | 24. FUNERAL DIRECTOR ADDRESS: Peninsula General Hospital, Salisbury, Md

VS. A15

RECEIVED
OCT 12 1949
BUREAU V. S.

Evidence for addition in #18 shown on:

10164

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

FUM No. G 1[illegible] NOV 28 1949

Reg. Dist. No. 335

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital	STREET ADDRESS (If rural, give location) 301 Riverview Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Infant		Jones	October	25	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday: yrs.	If under 1 year: Months.	Days	If under 24 hrs: Hours	Min.
male	White		10/23/49			2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Peninsula General Hosp. Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Jones	Elsie E. Enstel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		None	William S. Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Aspiration, apparently amniotic fluid	Immediate
762.5 Antecedent cause(s)		
159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Prematurity	
	(c) Autopsy - revealed only bronchioles filled with "desquamated epithelial cell." (11/28/49 DS)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 23, 1949, to Oct 25, 1949, that I last saw the deceased alive on Oct 25, 1949, and that death occurred at 5:35 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
William C. Morgan M.D.	502 N. Division St	10/26/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	10/27/49	Riverton Church	Riverton	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/26/49	Walter G Mann	The Hall & Johnson Co	Shapleytown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 29 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10166

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Wicomico — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Haven — LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Haven
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) HAYES (Last) LARMORE

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 6, 1879

9. AGE last birthday: 70 yrs. If under 1 year: Months 0 Days 0 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman & Farmer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): White Haven, Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alfred Larmore

14. MOTHER'S MAIDEN NAME: Phyllis Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If year, give war or dates of service): —

16. SOCIAL SECURITY No.: 212-16-7254

17. INFORMANT: Mrs. Robert Larmore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Obstructive Jaundice	1 month
157 Antecedent cause(s)		
469 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma Head of Pancreas.	2
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN): —
(COUNTY): —
(STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 Sept., 1949, to 6 Oct., 1949, that I last saw the deceased alive on 6 Oct., 1949, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Roland H. Saunders M.D.
ADDRESS: Nanticoke
DATE SIGNED: 10/7/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Oct. 9, 1949
NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
LOCATION (City, town, or county) (State): White Haven Md.

DATE REC'D BY LOCAL REG. 10-7-49
REGISTRAR'S SIGNATURE: Mary D. Holloway Deputy
24. FUNERAL DIRECTOR: C. T. Massick
ADDRESS: Bivalve, Md.

VS. A15

RECEIVED
OCT 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10167

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Wicomico — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Willards
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Willards
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) T. (Last) Lewis

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Dec 10, 1877

9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Wife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Truitt

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Clarence Truitt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Cerebral Hemorrhage

131 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr. Myocarditis & Nephritis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Willards (CITY OR TOWN) Wicomico (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to Oct, 1949, that I last saw the deceased alive on Oct 1, 1949 and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE: Chas R. Lew. M.D. (Degree or title) ADDRESS: DATE SIGNED: 10-7-49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial — DATE THEREOF: Oct. 8 1949 — NAME OF CEMETERY OR CREMATORY: New Hope — LOCATION (City, town, or county) (State): Willards, Md.

DATE REC'D BY LOCAL REG.: 10-8-49 — REGISTRAR'S SIGNATURE: Mary W. Dolloway Deputy

24. FUNERAL DIRECTOR: M. Pasha Watson — ADDRESS: Selbyville, Del.

VS-A15

RECEIVED
OCT 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10168

CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 113 W. College Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 113 W. College Ave.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Price (Last) Merrick
4. DATE OF DEATH: (Month) Oct. (Day) 26 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Nov. 18, 1858
9. AGE last birthday: 90 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Talbot Co. Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John F. Price
14. MOTHER'S MAIDEN NAME: Miranda J. Kemp
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If year, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: Mrs. E. J. Collings - Easton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153 **Immediate cause** (a) Carcinoma of Colon (Splenic flexure) — Interval Between Onset and Death: (?)

Antecedent cause(s)

1162 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Bronchopneumonia. — 5 days.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 20, 1946, to Oct. 18, 1949.; that I last saw the deceased alive on Oct. 18, 1949., and that death occurred at 3:06 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jalen H. Yeaman M.D. 238 Camden Ave, Salisbury, Md. 10-29-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Oct. 29, 1949 | NAME OF CEMETERY OR CREMATORY: Spring Hill | LOCATION (City, town, or county): Easton, | (State): Maryland.

DATE REC'D BY LOCAL REG. 10-28-49 | REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy | 24. FUNERAL DIRECTOR: R. Ellis Clark | ADDRESS: Easton, Md.

RECEIVED
OCT 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10169

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; LENGTH OF STAY (In this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Stockton Md.; STREET ADDRESS (If rural, give location) Rural ✓

3. NAME OF DECEASED (Type or Print): (First) Mr William (Middle) Jennings (Last) Merritt

4. DATE OF DEATH: (Month) October (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Jan 27-1897

9. AGE last birthday: 52 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor (Bird Eye Spinach)

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Thomas Merritt

14. MOTHER'S MAIDEN NAME: Susie Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 577-14-3388

17. INFORMANT: Mr Ralph Merritt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

145 Immediate cause (a) Carcinoma of Tonsil

45f Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-1, 1949, to 10-3, 1949, that I last saw the deceased alive on 10-2, 1949, and that death occurred at 7:50 A.m., from the causes and on the date stated above.

SIGNATURE Philip A Insley (Degree or title) ADDRESS Salisbury Md. DATE SIGNED 10-5-49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial | DATE THEREOF: Oct 5, 1949 | NAME OF CEMETERY OR CREMATORY: Stanton | LOCATION (City, town, or county) (State): Stanton, Md.

DATE REC'D BY LOCAL REG. 10-3-49 | REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy | 24. FUNERAL DIRECTOR: Henry H. Watson ADDRESS: Pokomoke. Md.

RECEIVED
OCT 6 1949
BUREAU V. S.

10170

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Dr. Moyer

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 1 Day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Delaware COUNTY Sussex
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel Route #3.
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) Mr Curb (Middle) ✓ (Last) Mullin

4. DATE OF DEATH (Month) Oct. (Day) 8th (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Mch 29-1892
9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James J. Mullin
14. MOTHER'S MAIDEN NAME Alveda Messick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If year, give war or dates of service) ✓
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Clara Mullin, Laurel Dela

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Arteriosclerotic Cardio-Vascular Disease

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary occlusion

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10, 1949, to 10/8, 1949, that I last saw the deceased alive on 10/7, 1949, and that death occurred at 10:20 A.m., from the causes and on the date stated above.

SIGNATURE Charles M. Moyer (Degree or title) ADDRESS Laurel Del DATE SIGNED 10/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 10/11-49
NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery
LOCATION (City, town, or county) Laurel Dela (State) ~~[illegible]~~

DATE REC'D BY LOCAL REG. 10-11-49
REGISTRAR'S SIGNATURE Mary W. Holloway Deputy
24. FUNERAL DIRECTOR J. Harvey Williamson
ADDRESS Federalsburg Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

RECEIVED
OCT 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10171

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parsonsburg. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS RD#1.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parsonsburg
STREET ADDRESS (If rural, give location) RD#1.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Virginia (Last) Wace
4. DATE OF DEATH: (Month) Oct. (Day) 17 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: May 29 1866
9. AGE last birthday: 83 yrs. | If under 1 year: Months 6 | Days 18 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10b. KIND OF BUSINESS OR INDUSTRY: Home work
11. BIRTHPLACE (State or foreign country): Arch Mills Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John R. Shanks
14. MOTHER'S MAIDEN NAME: Elizabeth Dugan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs. Lucy Hudelson (daughter) RD Parsonsburg Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

332 Immediate cause (a) Uremia

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Thrombosis

(c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 45, to Oct 17, 19 49, that I last saw the deceased alive on Oct 14, 1949, and that death occurred at 4.18 a. m., from the causes and on the date stated above.

SIGNATURE: William D Gray | (Degree or title): MD | ADDRESS: Salisbury Md | DATE SIGNED: 10/17/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Oct 19-49 | NAME OF CEMETERY OR CREMATORY: Parsonsburg Cem. | LOCATION (City, town, or county): Parsonsburg (State): Md

DATE REC'D BY LOCAL REG. 10-18-49 | REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy | 24. FUNERAL DIRECTOR: Holloway & Walter W. Holloway | ADDRESS: Salisbury Md

RECEIVED
OCT 20 1949
BUREAU T. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10172

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
HOSPITAL OR INSTITUTION OR STREET ADDRESS RD. #3	STREET ADDRESS (If rural, give location) RD #3

3. NAME OF DECEASED (Type or Print) (First) Joshua (Middle) James (Last) Parker

4. DATE OF DEATH (Month) Oct. (Day) 2nd (Year) 49

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Feb. 3-1884 | 9. AGE last birthday 65 yrs. | If under 1 year Months 7 Days 29 | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Wicomico Co. Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Parker | 14. MOTHER'S MAIDEN NAME Margaret E. Sturgis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS Mrs. Fannie C Parker (Wif)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage	6 days
331 Antecedent cause(s)	(b) Arteriosclerosis	? years
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertension, essential	? years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 27, 1949, to Oct 2nd, 1949, that I last saw the deceased alive on Oct 2nd, 1949, and that death occurred at 11:05 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) L. N. Sobler M.D. | ADDRESS East Street, Delmar Md. | DATE SIGNED 10-3-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Oct. 4-49 | NAME OF CEMETERY OR CREMATORY Charity Cem. | LOCATION (City, town, or county) R.D. Salisbury (State) Md.

DATE REC'D BY LOCAL REG. 10-3-49 | REGISTRAR'S SIGNATURE Mary W. Holloway Deputy | 24. FUNERAL DIRECTOR Holloway & Co. Salisbury Walter R. Holloway | ADDRESS Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-415

RECEIVED
OCT 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10173

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pittsville — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pittsville
HOSPITAL OR INSTITUTION OR STREET ADDRESS RD #2	STREET ADDRESS RD. #2 (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Eura (Middle) Benjamin (Last) Parsons

4. DATE OF DEATH (Month) Oct. (Day) 11 (Year) 49

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH May 25-1881 | 9. AGE last birthday -68 yrs. | If under 1 Months. 1 year Days 16 | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Pittsville Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph J. Parsons | 14. MOTHER'S MAIDEN NAME Sallie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS Mrs. Edith M. Parsons (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Myocarditis chronic — 2 yrs

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION ~ | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, 19..., to day of death that I last saw the deceased alive on Oct 10, 1949, and that death occurred at 6.30a m., from the causes and on the date stated above.

SIGNATURE Frank R Lewis (Degree or title) M.D. ADDRESS Willards Maryland DATE SIGNED 10-13-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Oct. 13-49 | NAME OF CEMETERY OR CREMATORY Old St. Johns Cem. | LOCATION (City, town, or county) Near Pomeltville (State) Md.

DATE REC'D BY LOCAL REG. 10-13-49 | REGISTRAR'S SIGNATURE Mary W. Holloway Deputy | 24. FUNERAL DIRECTOR Holloway & C. Salisbury ADDRESS Md. Walter K. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

RECEIVED
OCT 16 1929
BUREAU V. S.

Evidence for addition in #18 shown on:

10174

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

FHM No. G 122 NOV 23 1949

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hebron
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Railroad Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hebron
STREET ADDRESS (If rural, give location) Railroad Ave

3. NAME OF DECEASED (Type or Print): (First) William (Middle) James (Last) Phippin

4. DATE OF DEATH: (Month) Oct (Day) 11 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct 18 1914

9. AGE last birthday: 34 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.: 23

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hebron Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Marion C. Phippin

14. MOTHER'S MAIDEN NAME: Myrtle E. Fitzgerald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs Marion C. Phippin (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

193 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 2 days

Antecedent cause(s)

54b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Tumor of Brain - Malignant & primary site (11/23/49 JS) — 4 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 11th, 1949, to Oct 11th, 1949, that I last saw the deceased alive on Oct. 11th, 1949, and that death occurred at 9 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): William Emrich M.D. — ADDRESS: Hebron Md. — DATE SIGNED: Oct 13-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 14 49 — NAME OF CEMETERY OR CREMATORY: Hebron Cem — LOCATION (City, town, or county) (State): Hebron Md.

DATE REC'D BY LOCAL REG.: 10-14-49 — REGISTRAR'S SIGNATURE: Mary D. Holloway Deputy

24. FUNERAL DIRECTOR: Holloway & Co — ADDRESS: Salisbury Md. — Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 17 1949
BUREAU V. S.

Dr Charles Fisher

10175

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 18 hours.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY Worster
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Juliet (Middle) J. (Last) Purnell

4. DATE OF DEATH (Month) October (Day) 30 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Dec. 9-1861
9. AGE last birthday 87 yrs. If under 1 year Months Days If under 24 hrs Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Snow Hill, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas D Purnell
14. MOTHER'S MAIDEN NAME Julia Ann Purnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs Richard B. Winder Snow Hill, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days.

490

Antecedent cause(s)

108

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/28, 1949, to 10/30, 1949, that I last saw the deceased alive on 10/29, 1949, and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE Chas T. Fisher M.D. (Degree or title) ADDRESS Salisbury, Md. DATE SIGNED 10/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov. 1/49
NAME OF CEMETERY OR CREMATORY Presbyterian
LOCATION (City, town, or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REG. 10-31-49
REGISTRAR'S SIGNATURE Mary W. Holloway Deputy
24. FUNERAL DIRECTOR Alex Emmis Snow Hill ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 4 1949
BUREAU V. S.

D Grasse.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10176

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): 209 First Street

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) (Last) Fuller

4. DATE OF DEATH: (Month) October (Day) 30 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Dec. 15-1863

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days / Hours / Min.: 10 / 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Wicomico Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard L. Parsons

14. MOTHER'S MAIDEN NAME: Hannah Elizabeth Parlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mr. George Pingle (daughter) 209 First St. Salisbury Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Congestive Heart Failure — 420.0 — Interval between onset and death: 10 days

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b): Arteriosclerotic Heart Disease — 93d

(c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/15, 1949, to 10/30, 1949, that I last saw the deceased alive on 10/30, 1949, and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Fred R. Grasse M.D. — ADDRESS: Salisbury, Md. — DATE SIGNED: 10/31/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov. 2-49 — NAME OF CEMETERY OR CREMATORY: Parlow Cem. — LOCATION (City, town, or county) (State): Near Pittsville Md.

DATE REC'D BY LOCAL REG.: 11-1-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy.

24. FUNERAL DIRECTOR — ADDRESS: Holloway & Co. 520 E. Church St. Salisbury Md.

RECEIVED
NOV 3 1919
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10177

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (In this place): 4 mouth
HOSPITAL OR INSTITUTION OR STREET ADDRESS: NaplesNurses Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Princess Anne
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Typo or Print): (First) Kate (Middle) D. (Last) Sigler

4. DATE OF DEATH: (Month) Oct. (Day) 23 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Jan. 14. 1877

9. AGE last birthday: 72 yrs. — If under 1 year: Months 9 Days 9 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Bromson, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Mattocks

14. MOTHER'S MAIDEN NAME: Mario Jane Starkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mr. Floyd R. Sigler

18. MEDICAL CERTIFICATION — Princess Anne, Md

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 8 days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Epilepsy

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1949, to Oct. 23, 1949, that I last saw the deceased alive on Oct 23, 1949, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE: Levin R Mann — (Degree or title) MD — ADDRESS: Salisbury Md — DATE SIGNED: 10/24/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 10-25-49 | NAME OF CEMETERY OR CREMATORY: Presbyterion Cemetery | LOCATION (City, town, or county) (State): Princess Anne, Md

DATE REC'D BY LOCAL REG.: 10-25-49 | REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy | 24. FUNERAL DIRECTOR: Levin R. Wilson | ADDRESS: Princess Anne, Maryland

VS. A15

RECEIVED
OCT 27 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10178

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hospital	STREET ADDRESS (If rural, give location): 616 E. William St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Margaret Amelia Strimpler	Oct 19 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White		Oct 14 1885	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	At Home	Mahoney City Pa	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
August Pasqway	Elizabeth Buckley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No. No		Mrs. Albert J. Strimpler (Husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Infarction	10 days
420.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Ca Lung Metastatic	Unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF ~~OPERATION~~	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 7, 1949, to Oct 19, 1949, that I last saw the deceased alive on Oct 18, 1949, and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas R Mann	MD	Salisbury Md	10/19/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Bur	10/21/49	St. Gabriel's Cem.	Hayelton Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-20-49	Mary W. Holloway Deputy	Holloway & Co. Walter R. Holloway	Salisbury Md.

VS. A15

RECEIVED
OCT 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10179

CERTIFICATE OF DEATH

Reg. Dist. No. 11 334

1. PLACE OF DEATH
COUNTY: Wicomico — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Delmar
LENGTH OF STAY (in this place): 8mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 100 W.State Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Delmar
STREET ADDRESS (If rural, give location): 100 W.State Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Steve	Brian	Sullivan	Oct.	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days.	If under 24 hrs. Hours	Min.
Male	White	Single	1-22-49	yrs.	8	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----------
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond Sullivan
14. MOTHER'S MAIDEN NAME: Irma Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ----
17. INFORMANT AND ADDRESS: Raymond Sullivan, Delmar, Delaware

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

7730 **Immediate cause** (a) unknown

Antecedent cause(s)

161 C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ? Craniostenosis (anterior fontanel closed at 8 mos.)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
no	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—			

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
—			m.		—

22. I hereby certify that I attended the deceased from 9/5, 19 9, to 9/20 19 9, that I last saw the deceased alive on 9/20, 19 9, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS		DATE SIGNED
Ernest M. Lawson	M.D	Delmar	Del	10/10/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-11-49	Mt. Olive Methodist	Delmar, Delaware

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
October 11. 49	Harry E. Hudson	H. E. Grant & Son	Delmar, Del.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15.

RECEIVED
OCT 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10180

CERTIFICATE OF DEATH

Reg. Dist. No. 32

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; STATE MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury; LENGTH OF STAY (in this place) 1 Day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Wico; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury; STREET ADDRESS (If rural, give location) 409 Camden Ave.

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) Anderson (Last) Throckmorton

4. DATE OF DEATH: (Month) 10 (Day) 19 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 25 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry W. Anderson

14. MOTHER'S MAIDEN NAME: Emily Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-10-7299

17. INFORMANT AND ADDRESS: Chas H. Taylor Jr. Yeaman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 1 day.

331 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last: (b) Arteriosclerosis — (?)

833a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15, 1949, to Oct 19, 1949, that I last saw the deceased alive on Oct 19, 1949 and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Chas H. Yeaman M.D. 238 Camden Ave Salisbury Md 10/19/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 10/21/49 | NAME OF CEMETERY OR CREMATORY: Parsons Cemetery | LOCATION (City, town, or county) (State): Salisbury Maryland

DATE REC'D BY LOCAL REG.: 10-22-49 | REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy

24. FUNERAL DIRECTOR ADDRESS: The Hill & Johnston Co.

RECEIVED
OCT 25 1949
BUREAU V. B.

Dr. Wm Smith

10181

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS-A15

1. PLACE OF DEATH · COUNTY: Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Wicomico COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury — LENGTH OF STAY (In this place): 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula Hospital	STREET ADDRESS (If rural, give location): 607 Rose St

3. NAME OF DECEASED (Type or Print)	(First) William	(Middle)	(Last) WAILES	4. DATE OF DEATH	(Month) Oct	(Day) 23	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: about 1879	9. AGE last birthday: about 70 yrs.	If under 1 year Months	Days	If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Creosote Plant	11. BIRTHPLACE (State or foreign country): Delmar, Del	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: Sandy Wailes	14. MOTHER'S MAIDEN NAME: Julia — Wailes						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If year, give war or dates of service) ✓	16. SOCIAL SECURITY No.: 213-14-6530	17. INFORMANT AND ADDRESS: Mrs. Mayme Wailes					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 Immediate cause (a) Cardiac failure

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Spontaneous intracranial Hemorrhage

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 18, 1949, to Oct. 23, 1949, that I last saw the deceased alive on Oct. 22, 1949, and that death occurred at 11 50 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm B. Smith	M.D.	502 N. Division St. Salisbury, Md	10/23/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 10-26-49	NAME OF CEMETERY OR CREMATORY: Green Acres Cemetery	LOCATION (City, town, or county): Salisbury, Wicomico	(State): Md.
DATE REC'D BY LOCAL REG.: 10-25-49	REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy	24. FUNERAL DIRECTOR: James F. Stewart, Salisbury, Md.	ADDRESS: 402 E. Church St	

RECEIVED
OCT 27 1949
BUREAU V. S.

Dr Sembley.

10182

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury Md
LENGTH OF STAY (in this place) 20
HOSPITAL OR INSTITUTION OR STREET ADDRESS 507 Ward St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE ~~507~~ Md COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury Md.
STREET ADDRESS (If rural, give location) 507 Ward St

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) M. (Last) Waters
4. DATE OF DEATH (Month) Oct (Day) 22 (Year) 1949

5. SEX female
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH April 1877
9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Tyaskin Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Jackson
14. MOTHER'S MAIDEN NAME Hattie — unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Ella Nutter.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	4 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) none	
	(c) none	

002

13b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of Rt. Hip

19a. DATE OF OPERATION April 24, 1948
19b. MAJOR FINDINGS OF OPERATION Fracture
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Salisbury (COUNTY) Wicomico (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) April 19, 1949 m. ~~p.m.~~
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? Fall

22. I hereby certify that I attended the deceased from June 2, 1949, to Oct 22, 1949, that I last saw the deceased alive on Oct. 22, 1949, and that death occurred at 8.45 P.m., from the causes and on the date stated above.

SIGNATURE G Herbert Sembly (Degree or title) MD
ADDRESS Salisbury, Maryland
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 25
NAME OF CEMETERY OR CREMATORY Tyaskin Cem
LOCATION (City, town, or county) Tyaskin Md (State) 10/22/49

DATE REC'D BY LOCAL REG. 10-24-49
REGISTRAR'S SIGNATURE Mary W. Holloway Deputy
24. FUNERAL DIRECTOR Booker M. Quest
ADDRESS Salisbury Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

I

T

RECEIVED
OCT 26 1949
BUREAU V. S.

10183

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH
COUNTY Wicomico — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 552 South Division St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Carey	White	October	3	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White		May 6 1859	90 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael Carey
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George Wilmer Fields

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Coronary Disease	About 1 wk
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Senility	—
(c)		

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept 28th, 1949, to Oct 3d, 1949, that I last saw the deceased alive on Oct 2d, 1949, and that death occurred at 5:45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. T. Fisher	M.D.	Salisbury, Md	10/3/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/5/49	St Johns Methodist	Fruitland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-5-49	Mary W. Holloway Deputy	The Pell & Johnson Co	Salisbury, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 7 1949
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10184

CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nanticoke
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nanticoke
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) SAMUEL (Middle) (Last) WHITE

4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: May 29, 1862

9. AGE last birthday: 87 yrs. — If under 1 year: Months 4, Days 10, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Wicomico Co, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: James F. White

14. MOTHER'S MAIDEN NAME: Sarah C. Renshaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Marie White

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Coma — Interval between onset and death: 1 day

4500 Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio sclerosis — 15 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 March 1947 to 9 Oct. 1949, that I last saw the deceased alive on 9 Oct 1949, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Richard H. Saunders M.D. Nanticoke Md 9/10/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 12, 1949 — NAME OF CEMETERY OR CREMATORY: Turners Cemetery — LOCATION (City, town, or county) (State): Nanticoke Md.

DATE REC'D BY LOCAL REG. 10-10-49 — REGISTRAR'S SIGNATURE: Mary L. McElroy Deputy

24. FUNERAL DIRECTOR: C. D. Messick — ADDRESS: Bivalve, Md

RECEIVED
OCT 12 1949
BUREAU Y. S.

Dr Grance

10185

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH — COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place): 15 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print): (First) Lucy (Middle) Etta (Last) Willey
4. DATE OF DEATH: (Month) October (Day) 28 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: April 8-1876
9. AGE last birthday: 73 yrs. — If under 1 year: Months, Days — If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Allen Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sidney Ingersoll
14. MOTHER'S MAIDEN NAME: Jane Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Mrs. Lillian Wright (daughter) 600 W. Main St. Salisbury Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Thrombosis — 2 hrs.

332

Antecedent cause(s)

83b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/25, 1949, to 10/28, 1949, that I last saw the deceased alive on 10/28, 1949, and that death occurred at 11:59 p.m., from the causes and on the date stated above.

SIGNATURE: Fred R. Grance — (Degree or title) M.D. — ADDRESS: Salisbury Md. — DATE SIGNED: 10/29/49

23. BURIAL, CREMATION REMOVAL (Specify) — DATE: Oct. 31-49 — NAME OF CEMETERY OR CREMATORY: Allen Cem. — LOCATION (City, town, or county) (State): Allen Md

DATE REC'D BY LOCAL REG.: 10-31-49 — REGISTRAR'S SIGNATURE: Mary W. Holloway Deputy — 24. FUNERAL DIRECTOR: Holloway & Co. — ADDRESS: Salisbury Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 4 1949
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10186

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH — COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Manokin

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE Maryland — COUNTY Wico.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) Manokin

3. NAME OF DECEASED (Type or Print) (First) Beatrice (Middle) Barnett (Last) Williams
4. DATE OF DEATH (Month) October (Day) 31 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Aug. 17, 1873
9. AGE last birthday 76 yrs. — If under 1 year: Months, Days — If under 24 hrs: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John W. Barnett
14. MOTHER'S MAIDEN NAME Mary Jane Martin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Mrs. Q. H. Underhill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 Immediate cause (a) Cerebral Hemorrhage — 4 days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 26th, 1949, to Oct. 30th, 1949, that I last saw the deceased alive on Oct. 30th, 1949, and that death occurred at 11.00 P.m., from the causes and on the date stated above.

SIGNATURE William Emrich MD (Degree or title) — ADDRESS Helford Md — DATE SIGNED 11-1-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Nov. 4, 1949 — NAME OF CEMETERY OR CREMATORY Parsons Cemetery — LOCATION (City, town, or county) Salisbury, (State) Md.

DATE REC'D BY LOCAL REG. 11-2-49 — REGISTRAR'S SIGNATURE Mary W. Holloway Deputy — 24. FUNERAL DIRECTOR The Hill & Johnson Co. — ADDRESS Salisbury, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 4 1949
BUREAU P. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10187

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury; LENGTH OF STAY (in this place) Since 8/28/49; HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital; STATE Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY Caroline; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Federalsburg; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Tillie (Middle) (Last) Willin

4. DATE OF DEATH: (Month) Oct. (Day) 11 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1/10/90

9. AGE last birthday: 59 yrs. If under 1 year: Months 9 Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louder Willin

14. MOTHER'S MAIDEN NAME: Sarah Stephens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Patient on admission to hospital.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval between onset and death: 4 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/28, 19 49, to 10/11/, 19 49, that I last saw the deceased alive on 10/10, 19 49, and that death occurred at 7:30 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

S. H. Louder M.D. Salisbury, Md. 10/11/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: October 13, 1949 — NAME OF CEMETERY OR CREMATORY: Eldorado Cemetery — LOCATION (City, town, or county) (State): Eldorado, Maryland

DATE REC'D BY LOCAL REG. 10-13-49 — REGISTRAR'S SIGNATURE: Mary M. Holloway Deputy

24. FUNERAL DIRECTOR ADDRESS: J. J. Frampton and Son, Federalsburg, Maryland

RECEIVED
OCT 15 1949
BUREAU V. S.